



# Eyecare Registration and History Form

195 Fairfield Avenue, Suite 2B, West Caldwell, NJ 07006

## 1 Patient Information

Date: \_\_\_\_\_  
Patient: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Gender:      M      F Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
  
                 Single      Married      Widowed  
                 Separated      Divorced

Patient SS# (Last 4 Digits): \_\_\_\_\_  
Occupation: \_\_\_\_\_  
\_\_\_\_\_

**Optical Shop Used:** \_\_\_\_\_

**Name of Primary Doctor** \_\_\_\_\_

Phone: \_\_\_\_\_

Town: \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

Phone: \_\_\_\_\_

Town: \_\_\_\_\_

## 2 Insurance

**Primary Insurance:** \_\_\_\_\_

Subscriber: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Subscriber & DOB: \_\_\_\_\_

Do you need a **referral** to see Dr. Salzano?      Yes      No

**Vision Plan:**      Yes      No

Name of Plan: \_\_\_\_\_

Member's Name: \_\_\_\_\_

Member's DOB: \_\_\_\_\_

Last 4 digits of SS#: \_\_\_\_\_

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with

\_\_\_\_\_ and assigned

directly to Dr. Salzano all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

### Responsible Party Signature:

Signature \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Vision Plans are for routine exams ONLY! Medical Plans are for problems, follow-ups or testing visits.**

## 3 HIPAA Privacy Authorization

Please list the names and relationships of the people with whom we can discuss your medical issues:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Today's Visit:    Routine    Problem    Date of Last Exam: \_\_\_\_\_

Do you wear glasses:    Yes    No    All the time    Driving    Reading

Do you wear contacts:    Yes    No

*Please bring glasses and contact information*

**If there are no changes from the last time you filled this form, initial and date here.** \_\_\_\_\_

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## Eye Health History

Please mark to indicate if you have had any of the following.

- |                            |                          |
|----------------------------|--------------------------|
| Bloodshot Eyes             | Glaucoma                 |
| Blurred Vision- Distance   | Headaches                |
| Blurred Vision - Near      | Itching Eyes             |
| Burning Eyes               | Light Sensitive          |
| Cataracts                  | Loss of Vision           |
| Color Vision Poor Crossed  | Macular Degeneration     |
| Eyes/Strabismus            | Migraine Headaches       |
| Discharge from Eyes        | Night Vision Poor        |
| Dizzy Spells               | Red Eyes                 |
| Double Vision              | Retinal Disease          |
| Dry Eyes                   | Seeing Halos             |
| Eye Infection              | Seeing Flashes           |
| Eye Injury                 | Temporary Loss of Vision |
| Eye Strain                 | Twitching Eyelid         |
| Eye Surgery                | Vision Poor              |
| Fainting Spells, Blackouts | Watering Eyes            |
| Floaters or Spots          |                          |

### Family Eye History: Check all that apply

Cataracts    Glaucoma    Macular Degeneration    Retinal Disease

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## Medications

## Allergies

List the medications you are currently taking, including eye drops:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List your allergies to medications or other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## Health History

Please mark to indicate if you have had any of the following.

- |                        |                     |                    |
|------------------------|---------------------|--------------------|
| AIDS/HIV               | Drug Sensitivity    | Lupus              |
| Arthritis              | Emphysema           | Pacemaker          |
| Artificial Heart Valve | Epilepsy            | Rheumatic Fever    |
| Asthma                 | Hay Fever           | Shingles           |
| Bleeding               | Heart Condition     | Skin Conditions    |
| Cancer                 | Hepatitis (Type___) | Stroke             |
| Chemical Dependency    | High Blood Pressure | Thyroid Conditions |
| Diabetes               | Kidney Disease      | Tuberculosis       |

If Under 18

Birth History: #Weeks \_\_\_\_\_ Complications \_\_\_\_\_

Tobacco use

Alcohol Use

Eye Surgery: Type \_\_\_\_\_ Year \_\_\_\_\_

Surgery(Other): Type \_\_\_\_\_ Year \_\_\_\_\_

If there are no changes from the last time you filled this form, initial and date here. \_\_\_\_\_



# Refraction/Testing Waivers

## MEDICARE PATIENTS ONLY

MEDICARE WILL **NOT** COVER THE COST OF THE REFRACTION.

**\*\*Refraction is the part of the exam that determines your prescription for either glasses or contacts.** We do submit to secondary insurance, however, we do not know how much your insurance will cover, **if any**. The most this service will cost you is **\$65.00 and you will receive a prescription for glasses and/or contacts.**

I understand that Medicare **will NOT** cover the cost of this service. I agree to be personally and fully responsible for payment. That is, I will receive a bill and be financially responsible if any secondary insurance doesn't cover this service.

Check one:

Yes, I want to receive the items or services.

No, I have decided not to receive the items or services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL PATIENTS ONLY

### REFRACTION FOR GLASSES PRESCRIPTION

YOUR INSURANCE MAY OR MAY NOT COVER THE COST OF THE REFRACTION.

**\*\*Refraction is the part of the exam that determines your prescription for either glasses or contacts.** We do submit to your insurance however, we do not know how much your insurance will cover, **if any**. The most this service will cost you is **\$65.00 and you will receive a prescription for glasses and/or contacts.**

I agree to be personally and fully responsible for the payment once I receive a bill for this service.

Check one:

Yes, I want to receive the items or services.

No, I have decided not to receive the items or services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **VISION PATIENTS ONLY:**

### Office Visit/Testing Acknowledgement Form

I (or my dependent), \_\_\_\_\_ acknowledge that I will be billed for an **OFFICE VISIT** to address **non-routine eye exam** medical diagnoses and/or the **TESTING** done on this visit. Testing may include one or more of the following: digital photography, visual field, and/or optic nerve imaging. These charges along with the office visit **MAY OR MAY NOT BE** be paid for by my insurance. I acknowledge that I will be responsible for any balance due **after it is processed** through my insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# CHOOSE ONE OPTION

## CONSENT FOR DILATION

### Consent to use dilating DROPS

Dilating eye drops are used to enlarge the pupils, allowing Dr. Salzano to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating drops will usually cause blurred vision. Bright sunlight also can make it difficult to see. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired, varies from patient to patient.

Therefore, we strongly suggest you make arrangements for transportation. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. In addition, adverse reactions, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# OR

### Consent for Non-Mydriatic Fundus PHOTO

For a faster and more thorough eye exam, we are offering an ultra-widefield imaging system that replaces dilation. **Insurance WILL NOT pay** for this photography.

**The additional cost to you, our patient, is \$39.00**

**If you would like to take advantage of this specialized photography,  
Please sign the consent form below:**

I agree to pay the sum of **\$39** for a non-mydriatic fundus photograph of my eyes. This photograph is taken through **UNDILATED** pupils, and is used for the following purposes:

1. **Screening** for vitreoretinal and optic nerve pathology, such as glaucoma, macular degeneration, retinal tears, and retinal detachments.
2. **Documenting** the general health of the back portion of the eye (fundus), which we would not be able to see, otherwise, without dilation of the pupils.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*This charge is only for this procedure, and not for any other routine testing usually covered by insurance.



# Prescription Check Policy

With the increasing number of on-line and big-box retailers offering prescription eyewear, we've noticed a significant rise in glasses being made with incorrect prescriptions or improper lens measurements. It's important to understand that prescription lenses must be crafted with precise measurements—down to the millimeter—to ensure optimal visual acuity.

At Salzano Eye Center, we are committed to providing the highest quality care and eyewear for our patients. Unfortunately, we can no longer devote our resources to resolving issues caused by external providers that may prioritize cost savings over quality. We encourage all patients to trust our team for accurate, high-quality eyewear that meets the necessary standards for your best vision.

Thank you for understanding and supporting our efforts to provide exceptional eye care.

Sincerely,  
The Salzano Eye Center Optical Team

**I acknowledge the following regarding my glasses and prescription:**

**On-line and External Glasses Purchases**

- I accept that Salzano Eye Center is not responsible for the prescription (Rx), frame quality, or overall comfort of glasses purchased on-line or from other providers.
- Salzano Eye Center has no financial liability if my on-line or external glasses purchase is incorrect or must be remade.
- If I experience ongoing visual issues with glasses purchased from outside Salzano Eye Center, I understand that I should return to the place of purchase for any necessary adjustments or corrections.
- For on-line purchases, I will contact the supplier's support team for assistance in checking my prescription.
- If I request to have my eyewear checked by Salzano Eye Center only to confirm whether the glasses were made according to the prescription, there will be no charge.
- If a repeat refraction is necessary, optical staff may offer a refract-only visit with the prescribing ophthalmologist for **\$35**.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Check here for the visually impaired patient, or a patient who has just received drops. I acknowledge that this form was read aloud to me.

Read by: \_\_\_\_\_